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Date	10 November 2022	Agenda item	Bo.11.22.20

MATERNITY AND NEONATAL SERVICES UPDATE – OCTOBER 2022

Presented by	Sara Hollins, Director of Midwifery		
Author	Sara Hollins, Director of Midwifery		
Lead Director	Professor Karen Dawber, Chief Nurse		
Purpose of the paper	To provide the Quality and Patient Safety Academy and Trust Board with a monthly update on progress with the Maternity Improvement Plan, including CQC Action Plan, monthly stillbirth position and continuity of carer. Ensures that key elements of the Perinatal Clinical Quality Surveillance Model are visible and transparent at Trust Board level.		
Key control	Identify if the paper is a key control for the Board Assurance Framework		
Action required	For decision		
Previously discussed at/ informed by	Details of any consultation		
Previously approved at:	Academy/Group	Date	
	Quality and Patient Safety Academy QA.10.22.12a	26.10.22	

Key Options, Issues and Risks

The Maternity Service was rated as 'Required Improvement' following the November 2019 Care Quality Commission (CQC) inspection. The service has acknowledged the findings and recommendations, and is committed to addressing the issues raised and becoming an 'Outstanding' service.

Following Executive approval, the service embarked on a significant quality improvement and transformation project, intended to improve the stillbirth rate and other outcomes highlighted by the CQC, and ultimately support the journey towards being an outstanding maternity service.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. The service has improved the monthly review process and will provide the Board of Directors and Quality and Patient Safety Academy with a monthly stillbirth position, in order that they are fully informed and able to scrutinise and challenge as required.

The service reported an annual reduction in stillbirths during 2020, with a further reduction in 2021. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity and neonatal services report presented to the Board of Directors and Quality and Patient Safety Academy ensures that there is a timely and structured reporting

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mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity and neonatal services.

The format of this report supports the Trust level implementation of the Perinatal Clinical Quality Surveillance Model and ensures that key elements of the framework are visible and transparent at Trust Board level.

Analysis

The service has acknowledged the recommendations of the CQC 2019 report, and has incorporated them into the existing maternity action plan. The 'must, should, could' do actions and recommendations are summarised on the first page of the overarching action plan, with additional tabs providing more detailed descriptions of the actions required to evidence compliance. The overarching improvement plan has been updated to include the Ockenden Assurance action plan. Significant progress and compliance has been achieved with outstanding actions linked to major maternity transformation plans which are now complete (phase 1 theatre build). Recent internal audit of the CQC action plan was assessed as 'Significant Assurance'.

The service presented proposed transformation plans to Board of Directors in May 2020, focusing on key areas of improvement identified as necessary to reduce the stillbirth rate. The Outstanding Maternity Services Programme is now the key driver for transformation within the service and is well embedded within the culture of the unit.

Monitoring of the monthly stillbirth rate continues, with every case subject to a 72 hour review and discussion with the Executive, Non-Executive and Trust level Maternity Safety Champions. This process is well embedded, including the rapid identification and escalation of in-month 'spikes' in the stillbirth rate which are subject to thematic reviews and reporting of any findings and subsequent learning to Trust Board.

During the last 6 months of 2021, this monthly update paper included Neonatal harms and data, in addition to maternity. This is to ensure that neonatal harms, learning and improvements are visible at Board level.

Recommendation

Board of Directors is asked to note the contents of the Maternity and Neonatal Services Update, October 2022.

Board of Directors is asked to note the accompanying presentation regarding the recently published East Kent Maternity and Neonatal report, and to support the recommendations contained within:

- Note the content of the presentation and work currently being undertaken and new work planned
- Continued Commitment to the OMS Programme and acknowledgement that this will be one of the key drivers in delivering any future recommendations from the report

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- Continued commitment to receiving reports to each Public Board

Board of Directors is asked to support the recommendations contained in Appendix 1, Bi-annual Midwifery Staffing Paper, required to demonstrate compliance with Safety Action 5 of the Maternity Incentive Scheme, year 4.

- Taking the safety concerns highlighted in the Ockenden reports and the ongoing national midwifery staffing shortage into consideration, Trust Board is asked to continue to support the services proposal that the first priority is managing vacancy and recruitment to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care at 35%.
- Trust Board is asked to continue to support the long term commitment made in 2021 and again in March 2022, to fund the establishment required to provide MCoC as a default position. The 2021 Birth Rate plus report calculated this as requiring 279.77 WTE.
- The service requests that Board support the addition of a Specialist Midwife for Diabetes to the structure. This will be achieved by removing a band 6 from the midwifery establishment and will be a small cost pressure funding the difference from band 6 to 7.

Board of Directors is asked to approve Appendix 2, the Maternity Sustainability Improvement Plan, required by NHSE in order to exit the service from the Maternity Safety Support Programme

Board of Directors is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned available to Closed Board only. It is also asked to note that the number of stillbirths occurring in October triggered the internal escalation and review process.

Board of Directors is asked to note that there were 2 HSIB reportable Serious Incident's (SI) declared in October.

Board of Directors to note the ATAIN, Quarter 2 report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme.

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Risk assessment						
Strategic Objective	Appetite (G)					
	Avoid	Minimal	Cautious	Open	Seek	Mature
To provide outstanding care for patients			g			
To deliver our financial plan and key performance targets			g			
To be in the top 20% of NHS employers					g	
To be a continually learning organisation				g		
To collaborate effectively with local and regional partners					g	
The level of risk against each objective should be indicated. Where more than one option is available the level of risk of each option against each element should be indicated by numbering each option and showing numbers in the boxes.	Low		Moderate	High	Significant	
	Risk (*)					
Explanation of variance from Board of Directors Agreed General risk appetite (G)						

Benchmarking implications (see section 4 for details)	Yes	No	N/A
Is there Model Hospital data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is there any other national benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the Trust an outlier (positive or negative) for any benchmarking data relevant to the content of this paper?	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Risk Implications (see section 5 for details)	Yes	No	N/A
Corporate Risk register and/or Board Assurance Framework Amendments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Quality implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Resource implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Legal/regulatory implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diversity and Inclusion implications	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Performance Implications	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Regulation, Legislation and Compliance relevance	
NHS Improvement: (please tick those that are relevant)	
<input checked="" type="checkbox"/> Risk Assessment Framework	<input checked="" type="checkbox"/> Quality Governance Framework
<input type="checkbox"/> Code of Governance	<input type="checkbox"/> Annual Reporting Manual

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Care Quality Commission Domain: Choose an item.			
Care Quality Commission Fundamental Standard: Choose an item.			
NHS Improvement Effective Use of Resources: Choose an item.			
Other (please state):			
Relevance to other Board of Director's academies: (please select all that apply)			
People	Quality	Finance & Performance	Other (please state)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

1 PURPOSE/ AIM

The purpose of this paper is to provide a monthly update on progress with the Maternity Improvement Plan, including the Care Quality Committee (CQC) Action Plan, the monthly stillbirth position and continuity of carer. It also provides an update on the Outstanding Maternity Service quality improvement/transformation programme, intended to improve key areas of the service and support the journey towards being outstanding.

The paper also provides a brief narrative of the maternity outcomes and metrics reported in the monthly maternity dashboard.

Bradford is a regional and national outlier for stillbirths and concerns were raised by the CQC in November 2019 that the service had failed to identify a rising trend during 2019. This failing contributed to the 'Requires Improvement' rating applied to Maternity Services on 9 April. The service reported an annual reduction in stillbirths during 2020, with a further reduction in 2021. However, stillbirth reduction remains a key priority for the service as we continue to work towards the national ambition and 'halve it' trajectory.

The monthly maternity services report presented to Trust Board/Quality and Patient Safety Academy ensures that there is a timely and structured reporting mechanism of maternal and neonatal outcomes including learning from incidents, and that the Board has an open and transparent oversight and scrutiny of maternity and neonatal services as described in the Perinatal Clinical Quality Surveillance Model.

2 BACKGROUND/CONTEXT

Ockenden Report of Maternity Services at Shrewsbury and Telford NHS Trust, Ockenden Assurance Plan and East Kent Report

The Ockenden report of Maternity Services at Shrewsbury and Telford NHS Trust was published on 10 December 2020. The report looked at maternal and neonatal harms occurring between 2000-2019 at Shrewsbury and Telford Hospital and resulted in 27 recommendations

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for the named Trust with a further 7 early recommendations, referred to as immediate and essential actions (IAE's) to be implemented by all NHS Maternity services.

This was followed by the 2nd Ockenden Report on 30 March 2022 which included a further 15 1AE's. The national request is that Trust's continue to focus on embedding the original 7 IAE's and that a national plan will be developed following the publication of the East Kent report later in the year.

The service had its Regional Maternity Team assurance visit on 29 June. The visit was extremely positive and feedback very complimentary regarding the attitude and behaviours of the staff and unit. The team were assured by the evidence provided, which they were able to triangulate and test with staff and service users on the day. The full report was received in August and reflects the initial feedback presentation shared with Board in the July update paper.

The service shared the outstanding areas of compliance with the team, in relation to the audit of the use of the Personalised Care Plan (PCP) and our current lack of confidence with our ability to submit Maternity Services Data Set (MSDS) to the required standard.

The PCP is currently offered in paper format only and is held by the woman and not the service; this makes it impossible to robustly audit. The service is working towards the use of the Patient Portal, which will give women access to complete their individual PCP on line, and will be accessible to midwives and obstetricians to view and input as required. The service and IT colleagues are working closely to resolve the situation and are exploring the available options, none of which appear to meet the full PCP requirement. A solution continues to be sought by the service and IT colleagues. However, there has been no progress to report in October.

East Kent Report:

The Kirkup Report, 'Reading the signals: Maternity and neonatal services in East Kent- the Report of the Independent Investigation' was published on 19 October 2022 examining failings in maternity and neonatal services at The Queen The Queen Mother Hospital (QEQM) and the William Harvey Hospital (WHH), part of East Kent Hospitals University NHS Foundation Trust, between 2009 and 2020

A precis of the report and actions for the maternity service and Trust Board, accompanies this paper and is presented to November Board as a standalone agenda item.

A letter to Trusts from Ruth May, Stephen Powis and David Sloman sent on 20 October 2022, requesting that every Trust and ICB review the findings of the report at its next public board meeting, and for boards to be clear about the action they will take, and how effective assurance mechanisms are at 'reading the signals'.

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The key recommendations and request of BTHFT Trust Board are:

- Note the content of the presentation and work currently being undertaken and new work planned
- Continued Commitment to the OMS Programme and acknowledgement that this will be one of the key drivers in delivering any future recommendations from the report
- Continued commitment to receiving reports to each Public Board

As yet, there are no specific national actions requested of maternity services. However, it is anticipated that Trust's will be asked to bench mark themselves against the report by early spring 2023, with a focus on culture.

Any updates and progress relating to this report will be included in subsequent monthly update papers to Quality and Patient Safety Academy and Trust Board.

Midwifery Staffing

Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including minimum staffing in maternity services are taking place at Board level.

Current vacancy against the safe staffing establishment is 10.35 WTE which includes the agreed uplift for maternity leave. This is an improved position on that reported in September (18.1 WTE) and reflects the NQM who joined the service in October. Achieving the safe staffing establishment is our priority figure.

Current vacancy against the funded establishment, which includes the number of midwives required to provide Midwifery Continuity of Carer (MCoC) is 36.77 WTE.

Staffing gaps continue to be closely managed by the Bed Manager and staffing Matron of the day, utilising the amber risk assessment and escalation processes as required.

The service has offered 24 newly qualified midwives (NQM) posts to commence in October/November. We were delighted to welcome the first 10 of the NQM in October as they start their induction and supernumerary period. Further NQM will join us in the New Year and early spring time, with a small number deferred until next autumn due to maternity leave.

International recruitment continues at pace, with our first appointment arriving in early November.

Appendix 1 is a copy of the 2nd of this year Bi-annual Midwifery Staffing Paper, required to demonstrate compliance with Safety Action 5 of the Maternity Incentive Scheme.

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The paper has been presented to October People's Academy, and will be included in the overarching Nursing and Midwifery Staffing paper.

The requests for Trust Board are:

- Taking the safety concerns highlighted in the Ockenden reports and the ongoing national midwifery staffing shortage into consideration, Trust Board is asked to continue to support the services proposal that the first priority is managing vacancy and recruitment to achieve the Birth Rate plus calculated establishment for safe staffing, based on existing pathways and models of care at 35%.
- Trust Board is asked to continue to support the long term commitment made in 2021 and again in March 2022, to fund the establishment required to provide MCoC as a default position. The 2021 Birth Rate plus report calculated this as requiring 279.77 WTE.
- The service requests that Board support the addition of a Specialist Midwife for Diabetes to the structure. This will be achieved by removing a band 6 from the midwifery establishment and will be a small cost pressure funding the difference from band 6 to 7.

Obstetric Staffing

A detailed update was provided in the September paper presented alongside this paper at November Board. There is nothing additional to update. The Obstetric Staffing Risk Assessment will be ratified at November Core Governance Group and included in the November update paper.

Maternity Improvement Plan and CQC rating

Maternity Services received a 'Requires Improvement' rating in the 2019 inspection report published in April 2020. The service has acknowledged the recommendations including monitoring and escalation of stillbirth rates, monitoring and management of infection risks in maternity theatres, and have incorporated 'must, should and could' do's into the existing maternity action plan for immediate attention.

The 2019 CQC action plan has no open actions and is now 'business as usual, /ongoing monitoring. This is following the ratification of the Maternity Escalation guideline at September Women's Core Governance Group.

The action plan incorporates the Ockenden assurance actions as described earlier and outstanding actions from Serious Incidents (SI's) and a national benchmarking tab. It is reviewed as a minimum, 4-6 weekly by the Director of Midwifery, Clinical Director and Risk and Governance Lead Midwife.

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Following a successful visit from members of the Maternity Safety Support Programme (MSSP) in August, the improvement plan has been updated to include sustainability plans for the actions described. Trust Board is asked to note and approve the contents of Appendix 2, in order that it can be submitted externally to the Regional Chief Midwifery Officer and the MSSP team and will hopefully result in the service being exited from the support programme.

Members of the senior management team are meeting weekly with members of the Trust Quality and Safety team to review the action plan in preparation for an imminent CQC visit.

Stillbirth Position

There were 5 stillbirths in October. See appendix 3 available to Closed Board members. Table 1 is the running total of stillbirths in 2022, including the number of cases requiring further detailed investigation, and the number of butterfly babies whose deaths were expected.

1 of the 5 stillbirths was an expected death. However, the 4 other deaths prompted the internal escalation to the Chief Nurse and Deputy Medical Director.

All cases were presented and discussed in detail. Emerging themes included a recognition that the current financial crisis is impacting on the ability of some women to attend essential antenatal appointments.

This has triggered a review of what the service can do to support vulnerable women experiencing financial hardship and has resulted in a number of actions and initiatives including:

- Contact with the local bus company regarding the possibility of free buses from the City centre to the maternity unit or free/discounted bus travel for pregnant women- awaiting a response
- Provision of docket taxis for women who do not attend appointments declaring financial hardship as the barrier
- Bradford Metropolitan Food Bank is providing us with food bags to be a mini distribution centre
- 2 other local food banks have added us as referral agents

The service will also be undertaking a deep dive of all of the 2022 stillbirths to date, to see if a larger number reveals more themes/trends.

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Table 1:

Stillbirths 2022			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Butterfly babies	Number of cases
January	1	1	0	1
February	3	4	2	0
March	3	7	2	0
April	2	9	1	1 (level 1)
May	2	11	0	0
June	1	12	0	1 (HSIB SI)
July	3	15	1	0
August	6	21	0	1 (HSIB SI) 1 (level 1)
September	2	23	0	0
October	5	28	1	2 (HSIB SI)

Hypoxic Ischaemic Encephalopathy (HIE)

There were 0 babies requiring cooling for HIE in October.

Serious Incidents (SIs) and serious harms

The December 2020 Ockenden Report, independent review of Maternity services at the Shrewsbury and Telford Hospital NHS Trust, contained 7 immediate and essential actions (IAE) to improve care and safety in maternity services for all Trusts.

IAE 1: Enhanced Safety, recommends that all maternity SI reports and a summary of the key issues, must be sent to the Trust Board and the Local Maternity System (LMS).

There were 2 HSIB reportable cases occurring in October as described in appendix 3 available to Closed Board members.

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Safety Action 9 of the Maternity Incentive Scheme, Year 4, requires that there is evidence that discussions regarding safety intelligence, including the number of incidents reported as serious harm, themes identified and actions being taken to address any issues, are taking place at Board level.

There was 1 internal SI declared in October regarding a 4th Degree tear occurring in September. Details are provided in Appendix 3 as before.

Ongoing Maternity SIs:

There are 14 ongoing maternity SI's, 9 HSIB and 5 Trust level.

The Ockenden report is clear that neonatal harms should also be visible at Trust Board level. This report already covers monthly neonatal harms regarding care provided during pregnancy and birth, and has not previously featured neonatal harms regarding the care received after birth. This report features a brief description of any neonatal SI's declared in month, including any immediate lessons learned. It must be noted that the responsibility to escalate, investigate and action any learning, sits with the Neonatal Service and not the Maternity Service. The exception will be any case which crosses both specialties.

There were 0 neonatal SI's declared in October and no ongoing neonatal SI's under investigation.

Neonatal Deaths (NND)

There were 2 NND in October. Both babies were cared for on the Butterfly pathway and were examples of great MDT care and co-ordination by the recently appointed Palliative Care Specialist Midwife for Neonatal Unit.

Please see Table 2 below:

Table 2:

NND 2022			Expected deaths within total number	Further detailed investigation
Month	Number of babies	Running total	Extreme preterm/congenital anomalies/life limiting conditions	Number of cases
January	2	2	Expected preterm twins (not Bradford babies)	0

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February	0	2	0	0
March	0	2	0	0
April	1	3	0	0
May	3	6	1 (23 weeks non Bradford baby)	0
June	1	7	1 (known congenital anomaly on Butterfly Pathway)	0
July	2	9	2	0
August	3	12	1 (Termination of pregnancy born with signs of life)	0
September	4	16	2 (1 termination of pregnancy born with signs of life, 1 20 week miscarriage born with signs of life)	0
October	2	18	2	0

HSIB Cases and Progress in achieving Maternity Incentive Scheme Safety Action 10: Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification scheme?

Following the Ockenden Report, all cases referred to the Health Safety Investigation Branch (HSIB) will be declared as SI's. There were 2 cases meeting the HSIB referral criteria in October as previously described.

HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust

The implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

There were no direct requests for action made directly to the Trust in October.

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Coroner Regulation 28 made directly to Trust

Again, the implementation of a revised Perinatal Quality Surveillance Tool as per Ockenden recommendations, suggests that reporting on this is a monthly minimum data measure for Trust Board overview.

The service can confirm that there have been no such requests to date this year.

Maternity and Neonatal Bi-Monthly Safety Champion meetings

The Maternity and Neonatal Maternity Safety Champions did not have a planned meeting in October and are due to meet in November.

Monthly staff feedback from Safety Champions and walk-rounds

Members of the maternity and neonatal team met with Karen Dawber in October. Issues discussed included the ongoing visiting challenges on M4. A trust wide visitor's charter is in progress and maternity services will be included in this. There is also national pressure to allow partners to resume overnight visiting on the postnatal ward, and the ward areas have been asked to discuss how they plan to implement this. Karen Dawber and Sara Hollins also attended the Community Midwifery forum which gave an opportunity to share information and listen to the views and concerns of staff who have less opportunity to meet face to face.

Maternity Unit Diverts

In the 2019 inspection, the CQC commented on the number of times the maternity unit 'diverted' services. Unfortunately there is no national, regional or LMS level benchmarking available which would highlight the service as an outlier.

The NHSI maternity support team have also indicated that they believe that the service 'diverts' more frequently than other organisations. In response, the service agrees that a more robust process is required to review unit diverts, which will identify any themes requiring interrogation.

There was 1 partial divert in October recorded on Datix or the closure log. This was triggered by an increase in activity and acuity versus the number of available staff. 2 women were diverted to neighbouring units.

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Table 4:

MONTH	Full Divert	Partial Divert	Attempted Divert	Number of women diverted
JANUARY	0	1	1	3
FEBRUARY	0	1	0	1
MARCH	0	1	0	5
APRIL	0	4	0	TBC
MAY	0	0	2	0
JUNE	0	0	0	0
JULY	0	3	1	6
AUGUST	0	1	2	2
SEPTEMBER	0	1	0	2
OCTOBER	0	1	0	2
Total	0	13	6	21

Midwifery Continuity of Carer (MCoC) Action plan

There has been no further progress on MCoC due to the ongoing focus on safe staffing. Clover and Acorn team have paused the provision of intrapartum care to facilitate staffing support elsewhere in the service. However, the vulnerable women booked with those teams continue to receive an enhanced level of antenatal and postnatal care, and may still receive care from a team member allocated to work in the intrapartum area. This position is currently being reviewed to ascertain the feasibility of resuming intrapartum care in December.

Maternity Dashboard

The Maternity Dashboard has not been updated since Cerner Maternity Go-Live due to ongoing challenges with reporting and data quality.

The BI team continue to work closely with the Digital Midwife and Quality and Safety team to improve the quality of data available and the required reports.

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Training Compliance

The revised Perinatal Quality Surveillance Model minimum data set for Trust Board's, requires oversight of the training compliance of all staff groups in maternity related to the core competency framework and wider job essential training. Appendix 4 is a copy of the training compliance report presented to Board on a 3 monthly basis.

PROMPT compliance remains good for Midwifery and maternity support staff. There is a trajectory in place to bring the ODP's, anaesthetists and obstetricians up to the required 90% compliance before 4 December Maternity Incentive Scheme deadline. This will be achieved if everyone allocated attend the session.

There has been an improvement in safeguarding children, level 2, with the service now above the Trust target.

Safeguarding Adults, level 3, needs to be a focus for improvement.

Avoiding Term Admissions into Neonatal Units (ATAIN) Quarterly report

Appendix 5 is a copy of Quarter 2 ATAIN report, required to demonstrate compliance with Safety Action 3 of the Maternity Incentive Scheme.

Bradford ATAIN data remains below the national target of 5% at 4.23%.

Due to clinician capacity, there is a delay in reviewing all of the cases therefore this report does not currently contain any narrative regarding themes and trends, but will be added at a later stage.

Perinatal Quality Surveillance Model minimum data set for Trust Board's

Appendix 6 is the populated copy of the Perinatal Quality Surveillance Model minimum data set for Trust Board's. Much of the information required for presentation for Board is contained within the narrative of this report.

Outstanding Maternity Service Programme

The Outstanding Maternity Service (OMS) Programme is a transformation programme, intended to improve the service from 'Requires Improvement' to 'Outstanding'.

The programme contains 5 work streams:

- The Woman's Journey and Clinical Excellence.
- Moving to Digital.
- Streamlining Systems.
- A Building Fit for the Future.
- Investing In Our Workforce.

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Appendix 7 is a copy of the OMS September highlight report which details what has been achieved since the start of the OMS Programme. The October update describes progress on the last 3 workstreams.

Service User Feedback

Following a brief pause due to the step down of key personnel, there was a main meeting of the MVP held in October. BTHFT Maternity gave an update on key priorities and progress, but received no formal feedback in return.

There will be a further main meeting in December to discuss the relaunch of the MVP and plan the future structure and format of meetings in line with the National MVP toolkit.

3 PROPOSAL

The service proposes that the Maternity Improvement Plan incorporating the Ockenden assurance action plan is presented to Quality and Patient Safety Academy/Board of Directors on a monthly basis as part of this report.

The service also proposes that progress on the Outstanding Maternity Service programme is included in this monthly update.

Any urgent concerns emerging outside of the monthly reporting arrangements will be escalated by the Trust Level Safety Champions to the Board Level Safety Champion.

4 BENCHMARKING IMPLICATIONS

The service will continue to benchmark and monitor performance and position at both regional and national level, using the existing benchmarking tools including the Yorkshire and Humber regional maternity dashboard, MBRRACE-UK publications etc.

Continuity of Carer is monitored through the West Yorkshire and Harrogate LMS.

5 RISK ASSESSMENT

Stillbirths and Continuity of Carer pathways are on the maternity risk register, updated regularly and monitored through Women's Core Governance Group. All risks have been reviewed to reflect any increased risk as a result of changes to the service to maintain safety of women, babies and staff during the pandemic.

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6 RECOMMENDATIONS

Board of Directors is asked to note the contents of the Maternity and Neonatal Services Update, October 2022.

Board of Directors is asked to note the accompanying presentation regarding the recently published East Kent Maternity and Neonatal report, and to support the recommendations contained within:

- Note the content of the presentation and work currently being undertaken and new work planned
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Board of Directors is asked to acknowledge the monthly stillbirth position including the description of incidents and any immediate actions/lessons learned available to Closed Board only. It is also asked to note that the number of stillbirths occurring in October triggered the internal escalation and review process.

Board of Directors is asked to note that there were HSIB reportable Serious Incident's (SI) declared in October.

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Board of Directors to note the ATAIN, Quarter 2 report, required to demonstrate compliance with safety action 3 of the Maternity Incentive Scheme.

7 Appendices

- Appendix 1 Bi-annual mat staffing paper September 2022
- Appendix 2 Maternity Sustainability Plan
- Appendix 3 Closed Board Harms October 2022
- Appendix 4 Mandatory Training Report 03/10/22
- Appendix 5 ATAIN Q1 report 2022/23
- Appendix 6 Perinatal Quality Surveillance Model
- Appendix 7 September OMS Highlight Report